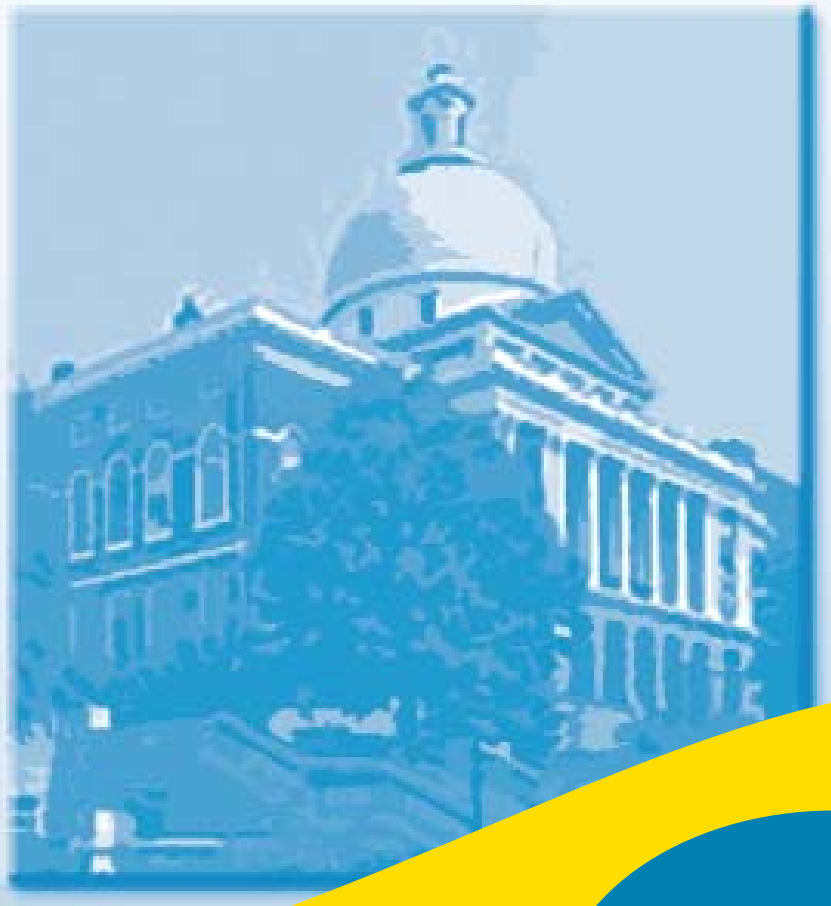
Commonwealth INDEMNITY PLAN

For Retired Municipal Teachers & Elderly Governmental Retirees

Benefit Updates and Important Information



SERIES 3
EFFECTIVE JULY 1, 2004

Commonwealth Indemnity Plan
Administered by UNICARE
www.unicare-cip.com

UniCare®

Updates to the Commonwealth Indemnity Plan Member Handbook

This booklet contains important updates to your Commonwealth Indemnity Plan coverage, effective July 1, 2004. Please keep this booklet, together with the Series 3 Member Handbook, in a convenient place for easy access when you need to refer to your health plan information. If you have any questions about these changes, please call the Commonwealth Service Center at **1-800-442-9300**, Monday through Friday between 8:30 a.m. and 5:00 p.m. If you are deaf or hard of hearing and have a TDD machine, contact us on our TDD lines at 1-800-322-9161 or 1-978-474-5163. A customer service representative will be happy to help you.

This benefit update has also been added to the Plan's web site, **www.unicare-cip.com**. This updated information will be included in the next printed revision of the Member Handbook.

Please Note: The page references in this document refer to Member Handbook pages, unless otherwise specified.

Important: Certain changes in this booklet apply only to **non-Medicare eligible** members, while others apply only to **Medicare eligible** members. Please look for the following headers to be sure you are reading the information that applies to you:

For Non-Medicare Eligible Members Only

For Medicare Eligible Members Only

For Both Non-Medicare Eligible & Medicare Eligible Members

For Non-Medicare Eligible Members Only

Benefit Highlights

Family Planning and Hormone Replacement Services

The title Family Planning Services on pages 34 is changed to read:

Family Planning and Hormone Replacement Services

Appendix B

Appendix B is deleted in its entirety and replaced with the following:

What You Should Know When You Use Non-Massachusetts Providers

This appendix contains important information about how the Commonwealth Indemnity Plan pays for services you receive from health care providers located outside of Massachusetts.

Reimbursement to Non-Massachusetts Providers
If you use a non-Massachusetts provider for any reason – including emergency care – you could be subject to balance billing. Balance billing is the practice by health care providers of billing patients for charges that exceed the amount paid by a patient's health plan for services rendered. For example, if your doctor bills your health plan $90 for your office visit and your health plan allows $75 for the office visit, some physicians may balance bill you for the difference of $15.

The following information explains how the Plan reimburses non-Massachusetts providers and how you may be able to manage or avoid balance billing by these providers.

The Plan pays non-Massachusetts providers according to fee schedules that establish the reasonable and customary allowed rates for payment of services. The payments in the fee schedules are consistent with what other plans pay providers. Charges in excess of the fee schedule amounts will not be considered for payment, as they will exceed these allowed amounts. A provider might balance bill you for the difference between the payment made by the Plan according to the fee schedules and the amount the provider charged.

Ways to Avoid Balance Billing
Here are two ways you can manage or even avoid balance billing:

- ***Use Massachusetts Providers for Your Health Care Whenever Possible*** – If you are planning any elective health care services, or need to schedule a medical or surgical procedure, you should consider using Massachusetts providers for that care whenever possible. These providers are prohibited by Massachusetts law from balance billing members of the Commonwealth Indemnity Plan for amounts above the allowed amounts established in the fee schedules.

  The Plan encourages you to plan ahead, scheduling medical care in Massachusetts before you go away, or upon your return. This will guarantee that you don't get balance billed.

- ***Discuss the Balance Bill with Your Non-Massachusetts Provider*** – Ask your provider to consider accepting the allowed amount from the Plan as payment in full for his or her services. The Commonwealth Indemnity Plan's fee schedules for out-of-state providers are intended to provide adequate compensation for services, usually at a level similar to – and sometimes higher than – what providers are receiving from many other health insurance plans in the area. Additionally, the Plan pays providers promptly; nearly 100 percent of provider claims are paid within 14 days of their receipt.

Using the Plan's Out-of-state Contracted Providers to Avoid Balance Billing
You or your eligible dependent may be able to participate in the Plan's program to help you avoid balance billing if you meet one of the following criteria:

1. you reside outside of Massachusetts – either permanently or for more than four consecutive weeks of the year – and receive services from non-Massachusetts providers, or
2. you have an eligible dependent who attends school outside of Massachusetts who receives services from non-Massachusetts providers

The Plan allows access to contracted providers outside of Massachusetts that you or your eligible student dependent can use for health care services, depending on where you or your dependent lives. These providers accept the Plan's fee schedules as payment in full and agree not to balance bill you. For more information on these contracted providers and how to use them, contact the Plan (see contact information below).

If you or your eligible child dependent plan to reside outside your home state for more than four consecutive weeks of the year, please call the Commonwealth Service Center at 1-800-442-9300 to report your new address. Or complete the temporary change of address form on our web site at **www.unicare-cip.com**. To locate this online form, click on "Other Claims Information," then select the link for information about avoiding balance billing. You'll find the link for the temporary change of address form at the bottom of this web page.

For More Information
For additional information about how to avoid being balance billed by non-Massachusetts providers, contact the Commonwealth Service Center at **1-800-442-9300.** You can also e-mail the Plan from its web site at **www.unicare-cip.com**; click on "Contact Us."

For Medicare Eligible Members Only

Benefit Highlights

Family Planning and Hormone Replacement Services

The subheading "Family Planning Services" on page 64 is changed to read:

Family Planning and Hormone Replacement Services

For Both Non-Medicare Eligible & Medicare Eligible Members

Important Plan Information

Involuntary Disenrollment Rate

In accordance with Division of Insurance regulations, UNICARE reports that its involuntary disenrollment rate among its members for its Massachusetts book of business was 0 percent in 2003.

Your Claims

Inquiry, Complaint and Grievances/Appeals Process

This subsection, which appears on pages 14-15 and 47-48, is deleted in its entirety and replaced with the following:

Inquiry, Complaint and Grievances/Appeals Process
The following procedures describe how the Plan handles member inquiries, complaints and grievances/appeals:

Internal Inquiry Process: The Plan provides an internal process for responding to inquiries. An "inquiry" is any question or concern communicated by you or your authorized representative to the Plan that is not related to an adverse determination. An adverse determination is a determination by the Plan, based upon a review of information, to deny, reduce, modify or terminate a hospital admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity; appropriateness of health care setting and level of care; or effectiveness.

The Plan maintains records of each member inquiry, and the Plan's response to the inquiry, for a period of two (2) years. These records are subject to inspection by the Commissioner of Insurance and the Department of Public Health.

Internal Grievances/Appeals Process: If your inquiry has not been explained or resolved to your satisfaction within three (3) business days of the inquiry, it automatically becomes a complaint. A "complaint" is either an inquiry made by you or your authorized representative to the Plan that is not explained or resolved to your satisfaction within three (3) business days of the inquiry, or a matter involving an adverse determination.

The Plan will provide you with a written notice that describes your right to have your complaint processed as an internal grievance/appeal. To initiate a grievance/appeal, contact the Plan at 1-800-442-9300, or send the grievance/appeal to the Plan in writing. For assistance in resolving grievances/appeals with the Commonwealth Indemnity Plan, call the Office of Patient Protection at 1-800-436-7757.

A "grievance/appeal" is any verbal or written complaint submitted to the Plan that has been initiated by you or your authorized representative regarding any aspect or action of the Plan relative to you, including but not limited to review of adverse determinations regarding scope of coverage, denial of services, quality of care and administrative operations.

Your request to initiate the internal grievance/appeal process should be made within 60 days of the Plan's notification to you that you have the right to have your complaint processed as a grievance/appeal. Your request should state why you believe the Plan did not resolve your complaint to your satisfaction or, in the case of an adverse determination, why you believe the determination was in conflict with Plan provisions. You should include all supporting documentation (at your own expense).

The Plan will provide you, or your authorized representative, with a written acknowledgment of the receipt of a grievance/appeal within 15 business days of its receipt of your grievance/appeal, whether it is received in writing or verbally through Customer Service. UNICARE will provide you, or your authorized representative, with a written resolution of your grievance/appeal within 30 business days of receipt of the verbal or written grievance/appeal. See "Time Requirements for Resolution of Grievances/Appeals" below.

Any grievance/appeal filed that requires the review of medical records must contain your written signature, or that of your authorized representative, on a form provided by the Plan. This form authorizes the release of medical and treatment information relevant to the grievance/appeal submitted to the Plan, when necessary, in a manner consistent with state and federal law. The Plan will request this authorization from you when necessary for grievances/appeals received through Customer Service, or for any written grievances/appeals that lack this authorization. You or your authorized representative will have access to any medical information and records relevant to your grievance/appeal that is in the possession of the Plan and under its control.

Time Requirements for Resolution of Grievances/Appeals: The Plan will provide you, or your authorized representative, with a written resolution of a grievance/appeal within 30 business days of receipt of the verbal or written grievance/appeal. The 30 business day time period for written resolution of a grievance/appeal that does not require the review of medical records, begins:

- on the day immediately following the three (3) business day time period for processing inquiries, if the inquiry has not been addressed within that period of time, or
- on the day you or your authorized representative notify the Plan that you are not satisfied with the response to an inquiry

The time limits specified above may be waived or extended by mutual written agreement between you, or your authorized representative, and the Plan. Any such agreement will state the additional time limits, which shall not exceed 30 business days from the date of the agreement.

When a grievance/appeal requires the review of medical records, the 30 business day period will not begin until you or your authorized representative submits a signed authorization for release of medical records and treatment information.

If the signed authorization is not provided by you or your authorized representative within 30 business days of the receipt of the grievance/appeal, the Plan may, at its discretion, issue a resolution of the grievance/appeal without review of some or all of the medical records.

A grievance/appeal not properly acted on by the Plan within the time limits will be deemed resolved in your favor. Time limits include any extensions made by mutual written agreement between the Plan and you or your authorized representative.

Grievances/appeals will be reviewed by an individual or individuals who are knowledgeable about the matters at issue in the grievance/appeal. Grievances/appeals of adverse determinations will be reviewed with the participation of an individual or individuals who did not participate in any of the Plan's prior decisions on the grievance/appeal. For the review of grievances/appeals of adverse determinations involving medical necessity, the reviewers will have included actively practicing health care professionals in the same or similar specialty who typically treat the medical condition, perform the procedure or provide the treatment that is the subject of the grievance/appeal.

In the case of a grievance/appeal that involves an adverse determination, the written resolution will include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and will, at a minimum:

- identify the specific information upon which the adverse determination was based
- discuss your presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria
- specify alternative treatment options covered by the Plan, if any
- reference and include applicable clinical practice guidelines and review criteria, and
- notify you or your authorized representative of the procedures for requesting external review, including the procedures to request an expedited external review

The Plan offers the opportunity to reopen a grievance/appeal about a final adverse determination when the relevant medical information was:

1. received too late to review within the 30 business day time limit, or
2. not received but is expected to become available within a reasonable time period following the written resolution

When you or your authorized representative request that a grievance/appeal about a final adverse determination be reopened and the Plan agrees with the request to reopen the grievance/appeal, the Plan will agree in writing to a new time period for review. However, in no event will this new time period be greater than 30 business days from the date of the agreement to reopen the grievance/appeal. The time period for requesting external review will begin on the date of the resolution of the reopened grievance/appeal.

Expedited Grievance/Appeal Process: An expedited grievance/appeal process is available for grievances/appeals concerning services, including durable medical equipment, that are needed on an immediate or urgent basis. If the issue involves ongoing inpatient hospital services, services to the terminally ill, or a case where delay could result in serious jeopardy to your life or health, the grievance/appeal may be handled through the expedited internal grievance/appeal process. This expedited process will be completed as follows:

- A written resolution will be provided prior to the date of discharge if the grievance/appeal is submitted by you during a period of ongoing hospitalization services.

  If the expedited review process results in an adverse determination regarding the continuation of inpatient care, the written resolution must inform you, or your authorized representative, of your right to request an expedited external review and your right to request continuation of inpatient services.

- A resolution of the grievance/appeal will be provided to you or your authorized representative within five (5) business days of receipt of the grievance/appeal if you have a terminal illness.

When a grievance is submitted by a member with a terminal illness, a resolution will be provided to you, or your authorized representative, within five (5) business days from the date of receipt of such grievance. If the expedited review process affirms the denial of your or your dependent's coverage or treatment and you or your dependent have a terminal illness, the Plan will provide you, or your authorized representative, within five (5) business days of the decision with a:

- statement setting forth the specific medical and scientific reasons for denying coverage or treatment
- description of alternative treatment, services or supplies covered or provided by the Plan, if any

In addition, you and/or your authorized representative have the right to have a conference with the Plan within 5 to 10 days of your request for a conference to discuss the resolution. The conference will be scheduled within 10 days of receiving your request, provided, however, that the conference will be held within five (5) business days of the request if the treating physician determines, after consultation with the Plan's medical director or his/her designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by the Plan, would be materially reduced if not provided at the earliest possible date.

Decisions will be provided within 48 hours for denials involving services or durable medical equipment if denial for such services or equipment will create a substantial risk of serious harm.

If an internal grievance is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment will remain in effect at the Plan's expense through completion of the internal grievance process, regardless of the final internal grievance decision. The ongoing coverage or treatment includes only that medical care that, at the time it was initiated, was authorized by the Plan.

How to File an Inquiry, Complaint or Grievance/Appeal
The Plan allows you to initiate an inquiry, complaint or grievance/appeal in the following ways:

1. By Mail: For requests relating to the Managed Care Review Program (inpatient hospital admissions; certain outpatient diagnostic and surgical procedures; durable medical equipment; home health care; physical and occupational therapy; and chiropractic and osteopathic manipulation), direct the request to:

Commonwealth Indemnity Plan
Appeals Review
P.O. Box 2011
Andover, MA 01810-0035

Send all other requests to:

Commonwealth Indemnity Plan
Appeals Review
P.O. Box 2075
Andover, MA 01810-0037

2. By Fax: Fax a written request to the Plan at 1-978-474-5165.

3. By Telephone: Call the Plan at 1-800-442-9300 to submit your request verbally to a customer service representative.

4. In Person: Submit your request to the Plan in person at the following address:

UNICARE
300 Brickstone Square, 8th Floor
Andover, MA 01810

External Review Process: Grievances/appeals involving coverage decisions based on medical necessity that are not resolved to your satisfaction after completion of the Plan's internal grievance/appeal process may be eligible for an independent external review through the Department of Public Health's Office of Patient Protection (OPP). You must file your request with OPP within 45 days of your written receipt of the adverse determination. OPP facilitates the external review process. To obtain the necessary forms, you must contact OPP at 1-800-436-7757, or access its web site at **www.mass.gov/dph/opp.**

Expedited External Review Process: While still an inpatient, you may request an expedited external review of an adverse determination if the treating physician certifies, in writing, that delay in the continuation of the inpatient services would pose a serious and immediate threat to your health. You may also request continuation of services if the subject matter of the external review involves the termination of ongoing services. Under these circumstances, you may apply to the external review panel to seek the continuation of coverage for the terminated service for the period in which the review is pending. The review panel may order the continuation of coverage or treatment where it determines that substantial harm to your health may result unless the services are continued, or for such other good cause as the review panel shall determine. Any such continuation of coverage shall be at the Plan's expense, regardless of the final external review determination. The expedited review decision will be issued within five (5) business days.

If a grievance/appeal is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment will remain in effect at the Plan's expense through completion of the internal grievance/appeal process, regardless of the final internal grievance/appeal decision. Ongoing coverage or treatment includes only that medical care that, at the time it was initiated, was authorized by the Plan and does not include medical care that was terminated pursuant to a specific time or episode-related exclusion from your contract for benefits.

If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage for the terminated service during the period in which the review is pending. Any such request must be made before the end of the second business day following receipt of the final adverse determination. The review panel may order the continuation of coverage or treatment where it determines that substantial harm to your health may result without such continuation, or for such other good cause as the review panel shall determine. Any such continuation of coverage shall be at the Plan's expense, regardless of the final external review determination.

You must submit requests for external review on a form provided by the Office of Patient Protection (OPP). Sign the form consenting to the release of medical information and include a copy of the written final adverse determination issued by the Plan. Also include a check for $25 to cover OPP's review. OPP may waive this fee if it would result in an extreme financial hardship to you.

Reporting Requirements

The Plan provides the following information to the Office of Patient Protection no later than May 15 of each year:

(a) a list of sources of independently published information assessing member satisfaction and evaluating the quality of health care services offered by the Plan

(b) the percentage of physicians who voluntarily and involuntarily terminated participation contracts with the Plan during the previous calendar year for which such data has been compiled, and the three most common reasons for voluntary and involuntary physician disenrollment

(c) the percentage of premium revenue expended by the Plan for health care services provided to members for the most recent year for which information is available, and

(d) a report detailing, for the previous calendar year, the total number of:

- filed grievances/appeals, grievances/appeals that were approved internally, grievances/appeals that were denied internally, and grievances/appeals that were withdrawn before resolution
- external appeals pursued after exhausting the internal grievance/appeal process and the resolution of all such external grievances/appeals

Managed Care Program

Utilization Management Program

The subsection **"Inpatient Hospitalizations"** on pages 20 and 51 is deleted in its entirety and replaced with the following:

Initial Review
The Commonwealth Indemnity Plan must review and determine the medical necessity of all inpatient hospital admissions. You or someone on your behalf must initiate this process by calling the Commonwealth Service Center at least seven (7) days in advance of a non-emergency admission, and within 24 hours of, or the next business day after, an emergency admission.

The purpose of this process is to inform you prior to a non-emergency admission, or as soon as possible after an emergency admission, whether the admission will be considered for benefits under the Plan. By calling the Commonwealth Service Center, you minimize your risk of incurring non-covered services.

Upon notification to the Commonwealth Service Center of your proposed admission or emergency admission, a patient advocate will contact your physician to discuss the medical necessity and appropriateness of the treatment plan and setting.

Initial Determinations: The Plan will make an initial determination regarding a proposed admission, procedure or services that requires such a determination within two (2) business days of obtaining all necessary information.

In the case of a determination to approve an admission, procedure or service, the Plan will notify, by telephone within 24 hours, the provider rendering the service, and will provide written or electronic confirmation of the telephone notification to you and your provider within two (2) business days thereafter. This notice will also specify the initial length of stay approved for the admission.

If the patient advocate is unable to confirm the medical necessity and appropriateness of the treatment, the inpatient hospital setting or the anticipated length of stay, a physician advisor will speak with your physician before the Plan makes a final decision.

Continued Stay Review
Your physician may recommend that you stay in the hospital beyond the initial number of days that the Plan has approved. In this case, the Plan will determine whether or not a continued hospital stay is medically necessary and appropriate.

You do not have to contact the Plan if your physician recommends that you stay in the hospital beyond the initial number of days approved by the Plan. The patient advocate will stay in touch with your physician while you are in the hospital, and work with the hospital staff to facilitate planning for care that may be required after your discharge.

Concurrent Review Determination: The Plan will make a concurrent review determination within one (1) business day of its receipt of all necessary information. In addition, in the case of a determination to approve an extended stay or additional services, the Plan will notify the provider by telephone or fax within one (1) business day thereafter to confirm that the stay has been approved. Such written or electronic notification will include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services.

If the patient advocate is unable to confirm that the continued hospitalization is medically necessary, a physician advisor will attempt to speak with your physician before the Plan makes a final decision. If the Plan determines that the continued hospitalization is not medically necessary, the patient advocate will notify the provider by telephone within 24 hours of receipt of all necessary information and will provide you with written or electronic notification within one (1) business day thereafter. Services will continue without liability to you until you or your authorized representative have been notified.

Any written notice concerning an adverse determination for continued hospitalization will advise you of your right to an internal expedited appeal with the right to a decision prior to discharge.

Adverse Determinations: In the case of an adverse determination, the Plan will notify the provider rendering the service of the adverse determination by telephone within 24 hours, and will provide written or electronic confirmation of the telephone notification to you and your provider within one (1) business day thereafter.

The Plan's written notice of adverse determination will include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and will:

- identify the specific information upon which the adverse determination was based
- discuss your presenting symptoms or condition; diagnosis and treatment interventions; and the specific reasons such medical evidence fails to meet the relevant medical review criteria
- specify any alternative treatment option offered by the Plan, and
- reference and include applicable clinical practice guidelines and review criteria

If you or your provider disagree with the adverse determination, you may seek reconsideration of ongoing services. A reconsideration may be requested by you or your provider. The reconsideration process gives your physician the opportunity to speak with another clinical peer reviewer who is not involved in the original adverse determination.

For an immediate reconsideration, the Commonwealth Service Center must receive requests and all supporting information within three (3) business days of the initial notification of denial. The reconsideration will be provided verbally within one business day of receipt of all necessary supporting documentation. The decision is then communicated in writing within two (2) business days to the patient and the patient's health care provider.

You may also use the Internal Inquiry, Complaint and Grievance/Appeal Process described on pages 5-8 of this booklet.

Appeals Process

The subsection entitled “Appeals Process” on pages 22 and 52 of the Member Handbook is deleted in its entirety. Please refer to the updated description of the Inquiry, Complaint and Grievances/Appeals Process in the Your Claims section of this document, which begins on page 4.

Healthcare Advisor™

On pages 23, 24 and 54 of the Managed Care Program section, under the heading “Making Healthy Decisions,” the term “Making Healthy Decisions” is deleted and replaced with the term “Healthcare Advisor™.”

Description of Covered Services

Coverage for Reconstructive Breast Surgery

Members of the Commonwealth Indemnity Plan are eligible for mastectomy benefits. As stipulated by federal legislation, coverage for reconstructive breast surgery in connection with a mastectomy may not be denied or reduced on the grounds that it is cosmetic or that it does not meet the Plan's definition of "medically necessary."

You are covered for reconstructive surgery, including reconstruction of the other breast to produce a symmetrical appearance. You are also covered for prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas. Benefits will be payable on the same basis as any other illness or injury, including the application of appropriate deductibles and coinsurance.

Emergency Treatment for an Accident or Sudden/Serious Illness

Massachusetts provides a 911 emergency response system throughout the state. If you are faced with an emergency, call 911. The Plan will cover medical and transportation expenses incurred as a result of the emergency medical condition in accordance with the terms of the Plan. In other states, check with your local telephone company about emergency access numbers. Keep emergency numbers and the telephone numbers of your physicians in an easily accessible location.

Family Planning Services

Subsection 11 (Family Planning Services) on page 69 is deleted in its entirety and replaced with the following:

11. **Family Planning and Hormone Replacement Services** – office visits and procedures for the purpose of contraception and services related to hormone replacement therapy for peri- and post-menopausal women. Office visits include evaluations, consultations and follow-up care. Procedures include fitting for a diaphragm or cervical cap; the insertion, re-insertion or removal of an IUD or Levonorgestrel (Norplant); and the injection of progesterone (Depo-Provera).

FDA approved contraceptive drugs and devices, as well as hormone replacement drugs, are available through the prescription drug plan.

Non-Prescription Enteral Formulas for Home Use

The following text is added to item 12 (Formulas, Special) on page 69 under Description of Covered Services:

Enteral formulas are not covered under the medical plan. Prescription and nonprescription enteral formulas are covered under the prescription drug plan only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

The medical plan does provide coverage for inherited diseases of amino acids and organic acids. The coverage includes food products modified to be low protein, for up to $2,500 per year per member.

Home Health Care

The following information is added to item 16 (Home Health Care) on page 70 of the Description of Covered Services section:

(e) Durable medical equipment (DME) and supplies provided as a medically necessary component of a physician-approved home health services plan.

Maternity Care

The following new coverage description is added to page 71:

Maternity Care – The Plan provides benefits for prenatal care, childbirth and post-partum care to the same extent as it provides benefits for other medical conditions.

The Plan will provide coverage of a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section for a mother and her newly born child. Any decision to shorten these lengths of stay will be made by the attending physician in consultation with the mother.

In the event of an early discharge, the Plan will cover:

(a) home visits

(b) parent education, assistance and training in breast or bottle feeding, and

(c) the performance of any necessary and appropriate clinical tests

Preventive Care Schedule for Children

The following information is added to Item (a) under Subsection 25 (Preventive Care Schedule) on page 72:

For children up to age 6 – The Plan covers the following tests as recommended by the physician:

- Hereditary and metabolic screening at birth
- Appropriate immunizations
- Tuberculin tests
- Hematocrit, hemoglobin or other appropriate blood tests
- Urinalysis
- Screening for lead poisoning for newly born infants and adoptive children

Transplant Services

The following is added to page 73 under Transplant Services:

Bone Marrow Transplant for Members Diagnosed with Breast Cancer
The Plan provides coverage for a bone marrow transplant or transplants for members who have been diagnosed with breast cancer that has progressed to metastatic disease, provided the member meets the criteria established by the Department of Public Health.

Limitations

The following is added to the list of Limitations on page 81:

Food products modified to be low protein, used for inherited diseases of amino acids and organic acids, are covered for up to $2,500 per year per member.

Plan Definitions

The definition for enteral therapy on page 84 is deleted and replaced with the following:

"Enteral Therapy" – prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines. Enteral formulas are not covered under the medical plan. Prescription and nonprescription enteral formulas are covered under the prescription drug plan only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

"**Preferred Vendor" –** The definition for "**Preferred Vendor"** on page 87 is deleted and replaced with the following:

"**Preferred Vendor**" – a provider contracted by the Plan to provide certain services or equipment, such as lab services or durable medical equipment. When you use Preferred Vendors you receive these services at a higher benefit level than when you use other providers for these services.

The following Plan definitions are added to the list of Plan definitions on pages 82-88.

"Adverse Determination" – a determination by the Plan, based upon a review of information, to deny, reduce, modify or terminate a hospital admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity; appropriateness of health care setting and level of care; or effectiveness.

"Complaint" – any inquiry made by you or your authorized representative to the Plan that is either not explained or resolved to your satisfaction within three (3) business days of the inquiry, or a matter involving an adverse determination.

"Inquiry" – any question or concern communicated by you or your authorized representative to the Plan that is not related to an adverse determination. The Plan maintains records of each member inquiry, and the Plan's response to the inquiry, for a period of two (2) years. These records are subject to inspection by the Commissioner of Insurance and the Department of Public Health.

"Grievance/Appeal" – any verbal or written complaint submitted to the Plan that has been initiated by you or your authorized representative regarding any aspect or action of the Plan relative to you, including but not limited to review of adverse determinations regarding scope of coverage, denial of services, quality of care and administrative operations.

General Provisions

Denial of Coverage

The following information has been added to page 89 of the General Provisions section, before "When Coverage Begins":

Coverage May Be Denied

Coverage may be denied if you are not an Elderly Governmental Retiree or a Retired Municipal Teacher, as defined by Massachusetts General Laws, Chapter 32A, and if you do not meet the Group Insurance Commission's eligibility rules and regulations.

When Coverage Ends for Enrollees

Item 5 under "When Coverage Ends for Enrollees," on page 90 of the General Provisions section is deleted and replaced with the following text:

5. the date the Commonwealth Indemnity Plan terminates*

* If the Plan is terminated due to the Commonwealth's nonpayment of required premium, your and your dependents' coverage under the Plan will terminate three (3) days after a notice has been mailed first-class to you at your last known address provided by the GIC. The notice will advise you that the Plan is terminated because the Commonwealth failed to pay the required premiums under the Plan and that the Plan will honor claims for covered services you received before the termination date.

When Coverage Ends for Dependents

On page 90 of the General Provisions section, under "When Coverage Ends for Dependents," item 9 is deleted in its entirety and replaced with the following:

9. the date the Commonwealth Indemnity Plan terminates, including if the Plan is terminated due to the Commonwealth's nonpayment of required premium. In this situation, you will be notified before such termination takes place, or

   (This subsection ends with item 10.)

Disenrollment

The following information has been added to page 90 of the General Provisions section, before "Continuation of Medical Expense Insurance Applicable Only to Massachusetts Residents":

Disenrollment

Voluntary Termination
You may terminate your coverage by notifying the Group Insurance Commission in writing. The GIC will determine the date on which your coverage will end.

Disenrollment Due to Loss of Eligibility
Coverage under the Plan may terminate or not renew if the member fails to meet any of the specified eligibility requirements. The member will be notified in writing if coverage ends for loss of eligibility. You may be eligible for continued enrollment under federal or state law, if your membership is terminated (see "Continuing Coverage" subsection).

Termination for Cause
The Group Insurance Commission may end a member's coverage for cause. The reasons for termination of membership may include, but are not limited to:

- Providing false or misleading information on an application for membership or misrepresentation or fraud on the part of the member
- The commission of acts of physical or verbal abuse by a member that pose a threat to providers, staff at providers' offices, or other members and that are unrelated to the member's physical or mental condition
- Non-renewal or cancellation of the GIC contract through which the member receives coverage

Group Health Continuation Coverage Under COBRA

All of the information regarding COBRA on pages 93-94 of the General Provisions section is deleted in its entirety and replaced with the text below. (The subsection entitled "Conversion to Non-Group Health Coverage" on page 94, which follows the COBRA information in the Member Handbook, remains the same.

This subsection contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

What Is COBRA Coverage?
COBRA, the Consolidated Omnibus Budget Reconciliation Act, is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called "Qualifying Events." If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This information explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617-727-2310, ext. 801, or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's web site at **www.dol.gov/ebsa.**

Who Is Eligible for COBRA Coverage?
Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts covered by the GIC's health benefits program, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced, or
- Your employment ends for reasons other than gross misconduct

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies
- Your spouse's employment with the Commonwealth ends for any reason other than gross misconduct or his/her hours of employment are reduced, or
- You and your spouse divorce or legally separate

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours of employment are reduced
- The parents divorce or legally separate, or
- The dependent ceases to be a dependent child (e.g., is over age 19 and is not a full-time student or ceases to be a full-time student)

How Long Does COBRA Coverage Last?
By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce – occurs during the 18 months of COBRA coverage.

You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage.

You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18-month COBRA period ends in order to extend the coverage.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA)
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability)
- The Commonwealth of Massachusetts no longer provides group health coverage to any of its employees, or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud)

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

How and When Do I Elect COBRA Coverage?
Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage**.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

How Much Does COBRA Coverage Cost?
Under COBRA, you must pay 102 percent of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150 percent of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

How and When Do I Pay for COBRA Coverage?
If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

Can I Elect Other Health Coverage Besides COBRA?

Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance "conversion" policy with your current health plan without providing proof of insurability. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

Your COBRA Coverage Responsibilities

- **You must inform the GIC of any address changes to preserve your COBRA rights.**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:
  - The employee's job terminates or his/her hours are reduced
  - The employee or former employee dies
  - The employee divorces or legally separates
  - The employee or employee's former spouse remarries
  - A covered child ceases to be a dependent
  - The Social Security Administration determines that the employee or a covered family member is disabled, or
  - The Social Security Administration determines that the employee or a covered family member is no longer disabled

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

Plan and Health Information Resources

Resources Available on the Plan's Web Site

The Plan's web site, **www.unicare-cip.com**, offers you an extensive range of Plan-related and general health care information and resources. These resources give you the ability to:

- check the status of your claims
- find out about the Plan's discounts on a variety of health-related products and services
- access information to help you understand and manage various health conditions and treatment procedures with the Healthcare Advisor™. This resource also provides profiles of health care facilities to help you assess where to best receive care, based on your needs and preferences.
- learn what's being done to improve patient safety in hospitals and how this information may help you select a hospital. Find out the extent to which hospitals in your area have implemented safety initiatives developed by the Leapfrog Group for Patient Safety and how frequently they have performed certain procedures.
- research medical information with the Healthwise Knowledgebase, an extensive online database of unbiased, up-to-date medical information
- access important Plan information, such as notification requirements
- view your Member Handbook and detailed descriptions of certain Plan benefits
- search for preferred vendors for services such as laboratory services and products such as durable medical equipment and medical supplies
- order Plan materials, e-mail the Plan and more

Express Scripts, Inc.
Prescription Drug Plan

Effective July 1, 2004

The information in this update contains important changes to the prescription drug benefit described on pages 100–104 of the Series 3 Member Handbook.

Benefit Changes

1. On page 100 under **Step Therapy**, in the list of prescription drugs requiring Step Therapy: the drug Glucophage XR® is removed from the list and the following drugs are added:

   Aciphex®, Accolate, Aceon®, Arthrotec®, Atacand®, Avalide®, Elidel®, Humira®, Kineret®, Lexxel®, Lexepro®, Lotrel®, Micardis®, Mobic®, Monopril®, Ponstel®, Protopic®, Strattera®, Tevetan®, Uniretic®, Zyflo®

2. On page 103, under **Prior Authorization**, Cerezyme® is removed from the list of drugs that require prior authorization.

   The drugs Tazorac®, Regranex®, Penlac®, Amevive®, Forteo® are added to the list of drugs that require prior authorization.

   The line, "For members over the age of 18: Dexedrine®, Desoxyn®, Adderall®", is removed in its entirety.

3. On page 104, in the **Exclusions and Limitations** section, the drugs Cialis® and Levitra® are added to the examples of drugs for which quantities may be limited.

United Behavioral Health

Mental Health, Substance Abuse and Enrollee Assistance Programs

Effective July 1, 2004

The following information is provided as a clarification to the information found in your Commonwealth Indemnity Plan Member Handbook for Medicare-Eligible and Non-Medicare-Eligible Retired Municipal Teachers and Elderly Governmental Retirees.

This Benefit Update is effective as of July 1, 2004.

United Behavioral Health Mental Health, Substance Abuse and Enrollee Assistance Programs

Part I – How to Use This Plan

Please replace the section titled "Let Us Show You the Benefits" in its entirety within "Part I – How to Use This Plan" on page 107 in your Commonwealth Indemnity Plan Member Handbook with the following:

The following describes your mental health, substance abuse and EAP benefits under the UBH plan. Please read it carefully before you seek care to ensure that you are receiving maximum benefits. The chart on pages 114-115 provides a brief overview of your benefits; however, it is not a detailed description and has changed slightly. A more detailed description of your benefits is found in Part III on pages 116-119. Words in italics in this description are defined in the "Definitions" section in Part II.

This is the "Description of Benefits" for your mental health, substance abuse and EAP services. While it is a full description of the available benefits under this plan, it is not the "Evidence of Coverage," the legal policy document that UBH submits to the Massachusetts Division of Insurance (DOI). The "Evidence of Coverage" governs the plan and includes state and federal mandated language, required disclosures to the Massachusetts Office of Patient Protection, continuation of coverage provisions as directed by state and federal law, and other required plan disclosures. The full "Evidence of Coverage" is available in electronic form and can be downloaded from the UBH website www.liveandworkwell.com (access code: 10910). If you would prefer a paper copy of this document, please send a written request to UBH at the address provided on page 109, and a copy will be sent to you free of charge.

Part III – Benefits Explained

The subsection entitled "Out-of-Network Benefits" is replaced in its entirety within "Part III – Benefits Explained" on page 118 of your Commonwealth Indemnity Plan Member Handbook with the following:

Out-of-Network Benefits

Outpatient Care – Out-of-network outpatient visits 1 through 15, which are deemed to be *covered services,* are paid at 80% of UBH's *allowed charges*, after your $75 annual *deductible* is met. Outpatient visits 16 and over that are *precertified* are paid at 50% of UBH's *allowed charges*. Out-of-network outpatient visits 1 through 15 do not require *precertification*, however, all outpatient out-of-network visits beyond session 15 require *precertification* with a *UBH Clinician* (call UBH toll-free 1-888-610-9039).

In-Home Care – Included in outpatient care visits and accumulates with other outpatient visits to determine the appropriate level of reimbursement. Out-of-network outpatient visits up to session 15, which are deemed to be *covered services,* are paid at 80% of UBH's *allowed charges*, after the appropriate annual *deductible* has been met. In-home care beyond session 15 requires *precertification*. *Precertified* out-of-network visits 16 and over are paid at 50% of UBH's *allowed charges*.

Intermediate Care – *Intermediate care,* which is deemed to be a *covered service,* is paid at 80% after the appropriate annual *deductible* has been met.

Inpatient Care – Out-of-network inpatient care, which is deemed to be a *covered service* for mental health care or substance abuse treatment, is paid at 80% in a general hospital, psychiatric hospital or substance abuse facility.

Each admission to a hospital or facility is subject to a $150 inpatient *deductible* per person in addition to the calendar year *deductible*. Failure to *precertify* inpatient care is subject to a *non-notification penalty* of $200 if the UBH case manager determines that the care is a *covered service*. No benefits will be paid if it is found not to be a *covered service*.

Drug Testing – There is no coverage for out-of-network drug testing.

See pages 119-121 for a list of Exclusions.

PO Box 9016
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Important Information Enclosed
Please Read